

## STUDENT HEALTH SCREENING CHECKLIST

*(Use with all preschoolers, kindergartners and new first graders.)*

Please complete the form below in order to help the school staff to better understand your child. Place a check beside items which describe your child most of the time.

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
First Middle Last Month/Day/Year

Nickname (if any): \_\_\_\_\_

Father's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_  
First Last First Last

With whom does child live? \_\_\_\_\_  
Name Relationship

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Who is this child's legal guardian? \_\_\_\_\_

Below, please list this child's brothers and sisters (if any):

Name	Birth year	Gender
1. School Attending: _____		
2. School Attending: _____		
3. School Attending: _____		

**DEVELOPMENTAL HISTORY**

1. Did the mother have any unusual physical or emotional illnesses during this pregnancy? \_\_\_ Yes \_\_\_ No
2. How old was the mother when this child was born? \_\_\_\_\_
3. Was the infant born full term? \_\_\_ Yes \_\_\_ No If not, how early or late? \_\_\_\_\_
4. What was the infant's birth weight? \_\_\_\_\_
5. Did the infant have any sickness or problems while in the nursery? \_\_\_ Yes \_\_\_ No
6. If yes to above, please briefly explain: \_\_\_\_\_
7. Please give the approximate age at which this child did the following:
  - Walked alone \_\_\_\_\_
  - Was toilet trained \_\_\_\_\_
  - Spoke in sentences \_\_\_\_\_
  - Dressed self \_\_\_\_\_
8. How does this child's development compare to other children, such as his/her playmates or siblings? Check Box.
  - About the same
  - Slower
  - Faster

**DEVELOPMENTAL:** Please check applicable items listed below:

- Plays well with other children
- Prefers to play alone
- Gets along well with adults
- Is shy
- Shares willingly
- Has temper tantrums
- Has a good appetite
- Eats a variety of foods
- Has some specific fears
- Specific Fear: \_\_\_\_\_
- Has a good attitude toward entering school
- Dresses self
- Attended Preschool - How Long: \_\_\_\_\_
- Where: \_\_\_\_\_

- Tires easily
- Is not toilet trained
- Sucks thumb
- Talks easily and willingly
- Knows full name
- Uses scissors
- Has been read to
- Reads some words
- Reads with little or no assistance
- Usually uses right hand
- Can follow simple directions
- Can put together simple puzzles
- Has speech problems

**HEALTH CONDITIONS** - Please check all that apply:

- Abnormal spinal curvature (scoliosis, etc.)
- Allergies or hay fever
- Anemia
- Arthritis
- Asthma or wheezing
- Bedwetting at night
- Behavior problem
- Birth or congenital malformation
- Cancer, type \_\_\_\_\_
- Chicken pox
- Chronic diarrhea or constipation
- Concern about relationship with siblings or friends
- Cystic fibrosis
- Diabetes
- Ear Problems
- Eczema
- Emotional problems
- Eye problems, poor vision
- Frequent headaches

- Frequent skin infections
- Frequent sore throat infections
- Heart disease, type \_\_\_\_\_
- Hepatitis
- Kidney disease, type \_\_\_\_\_
- Measles ("old fashioned" or "ten day")
- Meningitis or encephalitis
- Multiple ear infections (3 or more)
- Mumps
- Near-drowning or near-suffocation
- Nervous twitches or tics
- Poisoning
- Rheumatic fever
- Seizures or epilepsy
- Sickle cell disease
- Stool soiling
- Toothaches or dental infections
- Urinary tract infection
- Wetting during day

**ALLERGIES:** Please list and describe allergies or reactions to:

Medicines/drugs \_\_\_\_\_  
 Foods/plants/animals/other \_\_\_\_\_  
 Recommended treatment if allergy is severe \_\_\_\_\_

**INJURIES AND ILLNESSES:** Please list any severe injuries or illnesses:

Injuries/Illnesses	Age of Child	If Hospitalized (check)

**ADDITIONAL INFORMATION:**

What medications are given daily? \_\_\_\_\_

What medications are given frequently, but not daily? \_\_\_\_\_

**\*\*\* PLEASE NOTE: In order to administer medication at school, there must be a Beaver Creek Schools Medication form on file.**

This child is usually: very active \_\_\_\_\_ normally active \_\_\_\_\_ rather inactive \_\_\_\_\_

Do you have any concern about how your child gets along with other children? \_\_\_\_\_

Completed by: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Today's Date: \_\_\_\_\_

*Thank you for your cooperation.*